WISCONSIN MEDICAID

MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Mental Health Day Treatment Functional Assessment form, HCF 11090, must be completed each time a functional assessment is performed and kept with the recipient's case records. A mental health day treatment staff member, preferably the recipient's case manager or the primary staff person responsible for the recipient's treatment, is required to complete this form before treatment begins. Providers are required to submit a copy of Section I of this form (which includes demographic and client information) to Wisconsin Medicaid along with the Prior Authorization Request Form (PA/RF), HCF 11018, and the Prior Authorization/Adult Mental Health Day Treatment Attachment (PA/AMHDTA), HCF 11038. Providers should not submit this form with claims for payment.

This is a mandatory form. Wisconsin Medicaid will not accept other versions of this form. Print or type the information on the form so that it is legible.

SECTION I — DEMOGRAPHIC AND CLIENT INFORMATION

Element 1 — Name — Recipient
Print the recipient's last name, first name, and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Also include the recipient's name at the top of the second and subsequent pages.

Element 2 — Recipient's Medicaid Identification Number
Indicate the recipient's ten-digit Medicaid identification number. Use the recipient's Medicaid identification card or the EVS to obtain the correct identification number.

Element 3 — Date of Initial Assessment
Indicate the date the initial functional assessment was performed. Also include the date of initial assessment at the top of the second and subsequent pages.

Element 4 — Date of Reassessment
Indicate the date the functional reassessment was performed, if applicable. Also include the date of reassessment at the top of the second and subsequent pages.

Element 5
Complete the statement by indicating the total number of hours of day treatment the recipient has received since the initial assessment.

Element 6 — Referral Source
Check the appropriate type of referral.

Element 7 — Name / Agency — Referral Source
Indicate the name of the person or agency making the referral.

Element 8 — Address — Referral Source
Indicate the address, including the street, city, state, and zip code, of the person or agency making the referral.

Element 9
Indicate whether or not the client is presently an inpatient in an acute care general hospital or a psychiatric hospital or is a resident of a nursing home.

Element 10 — Name / Address — Facility
If the answer is "yes" to either question in Element 9, indicate the name and/or address, including the street, city, state, and zip code, of the facility.

Element 11
If the answer is "yes" to either question in Element 9, indicate the date the recipient became an inpatient or resident of the facility. Also indicate the anticipated discharge date (obtained from the facility).

Element 12 — Usual Living Arrangement
Check the appropriate box corresponding to the recipient's usual living arrangement.

Element 13 — Reason for Referral
State briefly the major reason(s) the person was referred to day treatment.

Element 14 — Eligibility Decision Criteria
The information requested in this element makes up the summary of data obtained through performing the complete functional assessment (Sections II-IV). Based on the information contained in this element, the recipient may or may not be eligible for Medicaid reimbursement of day treatment services.

a. *Substance abuse currently:* Indicate whether or not the recipient currently exhibits dependence on or abuse of alcohol or other drugs.

b. *Mental retardation primary diagnosis:* Indicate whether or not the recipient has a primary diagnosis of mental retardation. Mental retardation is defined as anyone with a diagnosis of 317, 318, or 319, according to the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).

c. *ICD-9-CM: Primary diagnosis code/Secondary and other code:* List the primary and secondary diagnoses using ICD-9-CM diagnosis codes.

d. *Scores, level of functioning (LOF):* Indicate the three scores from the functional assessment scale in the following order: 1) Task Orientation Scale, 2) Social Functioning Scale, and 3) Emotional Functioning Scale. Then add the scores for the total LOF score.

e. *Likelihood of Benefit:* Indicate the answer from Section V, Likelihood of Benefit from Mental Health Day Treatment.

f. *Course of Functioning*: Indicate the total score from Section V, Course of Functioning During the Past Year. The total score is the sum of the scores for indicators 1-5.

g. *Risk of Hospitalization:* Indicate the answer from Section V, Risk of Hospitalization.

Element 15 — Current Services Being Received (Medical and Nonmedical)
Indicate any services the recipient is receiving in addition to day treatment. For example, is the recipient receiving psychotherapy or occupational therapy in addition to day treatment from the provider's facility? Does the recipient attend a sheltered workshop? Does the recipient receive social work services from the county? Does the recipient have a guardian or advocate? These are the types of services (both medical and nonmedical) that should be indicated. If this information is not known, check with the referral source or the county/tribal social or human services agency of the recipient's place of residence.

Element 16 — Signature — Assessor
The person performing the functional assessment (e.g., case manager or primary staff person) is required to sign the form.

Element 17 — Discipline
Indicate the discipline of the assessor.

Element 18 — Date Signed
Indicate the date the form was signed by the assessor.

Element 19 — Signature — Day Treatment Program Director
The day treatment program director is required to sign after reviewing the assessment form.

Element 20 — Date Signed
Indicate the date the form was signed by the day treatment program director.

SECTIONS II-IV — LEVEL OF FUNCTIONING ASSESSMENT SCALES

In each of these sections, circle the indicators on the assessment scale that best describe the recipient's level of functioning. To score each scale, choose the number associated with the circled indicators. If the circled indicators are split between two numbers, score the scale using the lowest number in which indicators are circled, plus a decimal amount that indicates the percent of indicators beyond that number. For example, if on the Social Functioning Scale the provider circled indicators 3c, 3d, 4a, and 4b for a recipient, this scale would have a score of 3.5.

At the bottom of each section, indicate the score for that scale. At the bottom of Section IV, enter the total LOF score, which is the sum of the scores for all three scales (Sections II-IV).

SECTION V — SCORING

Likelihood of Benefit from Mental Health Day Treatment
Circle the appropriate level for the likelihood of benefit and enter the percent score in the scoring box to the right of the scale.

Course of Functioning During the Past Year
Circle the appropriate levels on each scale and enter the scores in the boxes to the right of the scales. Add the scores from scales 1-5 and enter the sum in the "Total (1-5)" scoring box.

Risk of Hospitalization
Circle the appropriate level for the risk of hospitalization and enter the percent score in the scoring box to the right of the scale.